OM 16-002 (version 2)
EFFECTIVE DATE: 28 MAR 2016

By Order of the Acting Assistant Director:
Stewart D. Smith, DHSc/s/

TO: IHSC Public Health Service (PHS) Commissioned Corps Officers, Civilian Federal Employees and Contract Personnel

SUBJECT: Significant Self-Harm and Suicide Prevention and Intervention

1. Applicability. This Operations Memorandum (OM) is applicable to all U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel, including but not limited to, Public Health Service (PHS) officers, federal employees and contract support staff. It is applicable to IHSC personnel supporting health care operations in both ICE-owned and contracted detention facilities, and to IHSC Headquarters staff.

2. Purpose. The purpose of this OM is to set forth the policies and procedures for preventing self-harm and suicide prevention and intervention. This OM supersedes IHSC Directive: 07-04, *Significant Self-Harm and Suicide Prevention and Intervention.*

3. General. The policy will ensure consistency and continuity of care to all detainees/residents (hereafter referred to as "detainees") to prevent significant self-harm and prevent potential suicides. The policy also recognizes that the screening for suicide ideation, plan and/or intent is an ongoing process that must occur throughout the period of custody of the detainee.

4. Definitions.

Potentially Suicidal Detainee – A potentially suicidal detainee has pre-occupations about suicide or self-injurious behavior without suicidal intent and plan. The detainee may present with a recent history of self-destructive/self-injurious behavior.

Actively Suicidal Detainee – An actively suicidal detainee has suicidal ideation with a plan and intent. The detainee may have taken steps to cause self-injury and the intent, whether implicit or explicit, or suicidal in nature.

Suicide Attempt Any nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Nonsuicidal Self-Directed Violence Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. Same as nonsuicidal self-injury.

Suicidal Intent There is evidence (explicit and/or implicit), that at the time of injury, the individual intended to kill self or wished to die, and the individual understood the probable consequences of his or her actions.

Suicide Gesture IHSC staff should not use this term in relation to suicidal detainees.

Suicide Watch Suicide watch always involves continuous visual observation of one detainee by one security staff member (one-to-one). All detainees on suicide watch must be housed individually in a cell deemed safe by custody staff and medical staff. Custody staff collaborate with on-site medical staff to review the cell housing a suicide watch detainee and ensure the cell is as suicide resistant as possible (e.g., no protrusions of any kind that would enable hanging or inflicting self-harm). Suicide watch detainees have their belongings and issued clothing removed, wear a suicide smock, use a suicide blanket, have a mattress to sleep on the floor or on a fixed bed, and are given food that can be consumed without the use of utensils (i.e., finger foods). Custody staff document welfare checks every (b)(7)(E) and a health care provider (registered nurse (RN) or higher) document a welfare check at least every 8 hours.

Constant Watch Constant watch is less restrictive than suicide watch. Constant watch involves continuous visual observation of one detainee by one security staff member (one-to-one); however, the detainee does not wear a suicide smock and does not use a suicide blanket. A regular food tray is provided. The detainee must be housed individually in a cell deemed safe by custody staff, have access to regular bedding materials that would be available for detainees not on suicide watch (i.e., regular bed, mattress, blanket, sheets and pillow). Constant watch maximizes safety while decreasing the potential counter-therapeutic impacts of the suicide smock and suicide blanket. Custody staff document welfare checks every (b)(7)(E) and a health care provider (RN or higher) must document a welfare check at least every 8 hours.

Mental Health Observation Mental health observation is less restrictive than constant watch. The detainee may be housed individually or with other detainees in the medical housing unit (MHU) or other non-general population housing area. Continuous visual observation is usually utilized. Custody staff performs staggered (b)(7)(E) welfare checks. A health care provider (RN or higher) must document a welfare check at least every 8 hours.

5. Policy and Procedures.

a. Staff Roles.

(1) Behavioral health providers (BHP) include psychiatrists, clinical psychologists, independently licensed social workers and psychiatric nurse practitioners.

(2) BHPs and primary care physicians are the only IHSC staff who can perform the initial evaluation of a detainee who is potentially suicidal or is on suicide watch. If none is available the detainee will be sent to the local emergency department for evaluation and treatment.

(3) BHPs and primary care physicians can perform the follow-up evaluation(s) of a detainee who is potentially suicidal or who is on suicide watch. If a BHP or primary care physician is not on-site, a mid-level provider (MLP) can perform the follow-up evaluation(s) but must send the progress note to the primary care physician for co-signature.

(a) If the MLP determines during the follow-up evaluation that the detainee is having an acute exacerbation, shows evidence of deteriorating status and/or requires a higher level of care, the MLP must immediately call the clinical director (CD) and on call BHP for a telephone consultation. This telephone consultation must be documented in the detainee's health record.

(4) BHPs and primary care physicians are the only IHSC staff that can discontinue suicide watch, constant watch or mental health observation.

b. Identification of Suicidal Detainees.

Suicide screening is done on intake of all newly arriving detainees. Any person who is identified in the intake process of being at risk of suicide because of ideation or intent will be referred immediately to medical for further in-depth evaluation by a BHP or primary care physician. Throughout the period of custody of a detainee, the BHP and other medical providers will routinely assess for the possibility of development of suicidal ideation, plan or intent by the detainee. Although there may be a higher incidence of suicidal thought at the beginning of custody there is a need to target other high risk periods, including when placed in segregation and upon return from court hearings that resulted in bad news. Those identified at risk will be referred to a BHP or primary care physician for full evaluation.

(1) At any time, during the period of custody, anyone (custody staff or medical staff) may identify a detainee who is potentially suicidal or actively suicidal, or a detainee may self-identify as being suicidal.

(2) If a detainee self-identifies or is identified as being potentially or actively suicidal (i.e., "at risk" for significant self-harm or suicide), the individual identifying this must notify medical staff immediately. The detainee must be brought to the clinic (if the detainee is not already there) and placed on suicide watch immediately.

(3) The detainee must be immediately referred to the BHP or primary care physician.

(4) Any detainee who expresses suicidal ideations or displays suicidal behaviors must be fully evaluated and considered "at risk" until it is fully determined otherwise by the

BHP or primary care physician. If neither is available, the patient will be sent to the local emergency department for evaluation and treatment.

(5) If the BHP or primary care physician determines that a detainee is at imminent risk of bodily injury or death, the BHP or primary care physician may make a referral to the local emergency department for evaluation and/or treatment, as indicated.

c. Referrals.

(1) Detainees who are identified as being potentially suicidal, actively suicidal or "at risk" for significant self-harm or suicide must be immediately referred to the BHP, primary care physician, CD or appropriate clinical designee.

(2) The referred BHP, primary care physician, CD or appropriate clinical designee must evaluate the detainee within 24 hours of referral and complete the appropriate suicide risk assessment form.

(3) The detainee must be placed on suicide watch with one-to-one continuous visual observation until the BHP, primary care physician, CD or appropriate clinical designee evaluates the detainee and renders a treatment decision.

(4) If the BHP or primary care physician is unavailable in the next 24 hours, or if the facility is not equipped to maintain suicide watch, the detainee must be sent off-site for evaluation.

(a) The health services administrator (HSA), CD or designee must coordinate the transfer of the detainee to the off-site facility for evaluation.

(b) Custody staff must maintain one-to-one continuous visual observation until the detainee is seen at the off-site facility and the off-site facility assumes care of the detainee.

d. Initial Evaluation/Suicide Risk Assessment.

(1) The BHP or primary care physician must assess the potentially suicidal, actively suicidal or "at risk" detainee for suicide risk factors and must engage in a full health record review leading up to and including time spent on suicide watch.

(2) Two suicide assessment forms have been developed to standardize the evaluation and medical record documentation when evaluating a suicidal detainee. These forms are the "Initial Suicide Risk Assessment" and "Follow-Up Suicide Risk Assessment" forms. Both of these forms are eClinicalWorks (eCW) Smart Forms.

(3) Only BHPs or primary care physicians can perform initial suicide risk assessments and must complete the "Initial Suicide Risk Assessment" form.

(4) The BHP or primary care physician must utilize the eCW Smart Form, "Initial Suicide Risk Assessment" (Appendix A), during the initial evaluation of any detainee at risk of suicide. This form must be included in the detainee's health record. This form includes:

(a) Psychological factors, including: previous and current mental health conditions/treatment, previous and current suicidal ideations/attempts and mental status examination.

(b) Lethality of suicide plan;

(c) Substance abuse/use;

(d) Important relationships; family history of mental conditions/suicide;

(e) Adjustment to detention;

(f) Environmental factors;

(g) Physical health/physical pain;

(h) Determination of level of suicide risk;

(i) Level of supervision needed;

(j) Referral/transfer for in-patient care, if needed; and

(k) Instructions to medical staff for care and monitoring.

(5) If the detainee requires suicide watch, staff must follow the Protocol for Suicide Watch (Appendix C).

e. Follow-Up Evaluation/Suicide Risk Assessment.

(1) The on-site BHP or primary care physician must evaluate detainees placed on suicide watch on a daily basis and use the eCW Smart Form, "Follow-Up Suicide Risk Assessment" (Appendix B). This form must be utilized for any suicide risk assessments after the initial risk assessment has been performed and prior to removal from precautions and/or suicide watch to document the daily observations in the detainee's health record.

(2) If the BHP or primary care physician is not on-site, an MLP should engage in the follow-up re-evaluation of detainees placed on suicide watch.

(a) The MLP must document findings from their evaluation in the progress note in the detainee's health record. The MLP must send the progress note to a primary care physician for co-signature. The MLP must not utilize the "Follow-Up Suicide Risk Assessment" form.

(3) If a detainee's mental health status remains unchanged or worsens (e.g., the detainee continues to exhibit suicidal ideation with intent) after 72 hours of being on suicide watch, the BHP or primary care physician must review the medical record, consider the detainee's full assessment and consider consultation with other BHP personnel, primary care physicians, and/or the CD regarding changes to the treatment plan and possible hospitalization.

(4) The CD or clinical designee must be updated on detainee status changes daily.

f. Treatment

(1) The BHP must develop a treatment plan based on the evaluation and assessment of the detainee. The BHP must document the treatment plan in the detainee's health record.

(2) The treatment plan must address the relevant factors that contribute to the detainee's suicidal ideation (e.g., environmental, historical, biological, psychological and social) and must be updated, as necessary.

(3) Contracts for safety (i.e., no-suicide contracts) are not considered safe and must not be utilized in the treatment plan.

(4) The BHP must assess the detainee's need for psychiatric evaluation, psychotropic medication, or possible inpatient psychiatric treatment due to self-harm, suicidal ideation or a suicide attempt. The BHP may refer the detainee to a psychiatrist or off-site facility for a more intensive level of management (e.g., psychiatric evaluation, medications and inpatient treatment).

(5) A detainee placed on suicide watch must remain on suicide watch for a minimum of 24 hours before suicide watch can be discontinued, by a primary care physician and/or psychiatrist.

(a) The primary care physician and/or psychiatrist may override the decision to keep a detainee on suicide watch based on their evaluation of the detainee and/or consultation with the BHP.

g. Housing and Monitoring

When placing detainees on and off watch, and monitoring for potential suicidal actions, the BHP or primary care physician must keep in mind the principle of "least restrictive environment". Therefore, unless the risk of suicide is considered imminently high, one should choose constant watch over suicide watch whenever possible, as both involve continuous visual observation of one detainee by one security staff member (one-to-one).

(1) The BHP or primary care physician may determine that the detainee is "potentially suicidal," "actively suicidal," or not suicidal at any given time. The housing and monitoring of these detainees are distinct.

(2) While on-site, a health care provider (RN or higher) must perform clinical rounds and document observations in the health record at least every eight hours. If the BHP or primary care physician determines that nursing rounds are needed more frequently, the BHP or primary care physician must determine the frequency and outline the specific instructions for nursing care.

(3) A potentially suicidal detainee must be removed from general population and must be placed in a setting where custody staff can observe the detainee at staggered intervals not to exceed (b)(7)(E) e.g., medical housing unit (MHU)).

(a) The potentially suicidal detainee must be under mental health observation and remain on this observation schedule until a BHP or primary care physician determines a change in status/suicide risk level.

(b) A health care provider (RN or higher) must check on the detainee at least every eight hours (or more frequently per the plan of care).

(c) The on-site BHP or primary care physician must evaluate and treat the detainee daily.

(d) The on-site BHP or primary care physician may discontinue mental health observation, if clinically indicated.

(4) An actively suicidal detainee must be removed from general population and must be placed in a single person room that is free of objects or structured elements that could facilitate a suicide attempt.

(a) Custody staff and medical staff must inspect the room used for suicide watch and must remove any objects or hazards that pose a threat to the detainee's safety.

(b) The actively suicidal detainee must be under suicide watch and continuous (i.e., 24 hours a day, seven days a week) one-to-one continuous visual observation by custody staff.

(c) Custody staff must document security staff welfare checks every (b)(7)(E) or more frequently, if necessary.

(d) A health care provider (RN or higher) must check on the detainee and document an assessment every eight hours (or more frequently per the plan of care).

(e) The on-site BHP or primary care physician must evaluate the detainee and document an assessment using the "Follow-Up Suicide Risk Assessment" eCW Smart Form (Appendix B).

1) If the BHP or primary care physician is not on-site, an MLP must evaluate the detainee and document findings from their assessment in the progress note in the detainee's health record. The MLP must send the progress note to the primary care physician for co-signature. The MLP should not use the "Follow-Up Suicide Risk Assessment" Form.

(f) The detainee must be under certain restrictions while on suicide watch. These restrictions include:

1) The detainee must be provided a suicide smock to wear. No other clothing is permitted. Special consideration for flexible appropriate attire should be given to detainees with special vulnerabilities (e.g., actively menstruating females, detainees who suffer from incontinence, detainees who have a colostomy). The BHP and/or primary care physician must authorize these changes before implementation.

2) Custody staff must take any belongings from the detainee and place the belongings in a secure area.

3) The detainee must only be provided food items that can be consumed without utensils (i.e., finger foods).

4) The detainee must not be permitted to go to recreation.

5) The detainee may receive phone calls while under supervision.

6) The BHP or primary care physician must authorize any movement of the detainee outside the suicide observation area (e.g., court, attorney visits), and continuous custody observation must continue outside the suicide observation area.

7) The BHP and/or primary care physician must authorize any changes made to these restrictions.

(g) The detainee must be under certain restrictions while on constant watch. These restrictions include:

1) Continuous visual observation of one detainee by one security staff member (one-to-one).

2) The detainee does not wear a suicide smock; he/she may wear the issued detention uniform.

3) Have access to regular bedding material (i.e., regular bed, mattress, blanket, sheets and pillow).

4) A regular food tray is provided.

5) The detainee must be housed individually in a cell deemed safe by custody staff.

6) Custody staff document welfare checks every (b)(7)(E) and a health care provider (RN or higher) must document a welfare check at least every 8 hours.

h. Discharge from Suicide Watch

(1) A detainee placed on suicide or constant watch must remain on suicide watch for a minimum of 24 hours before the watch can be discontinued, unless determined otherwise by a primary care physician and/or psychiatrist.

(a) The primary care physician and/or psychiatrist may override the decision to keep a detainee on suicide or constant watch based on their evaluation of the detainee and/or consultation with the BHP.

(2) The BHP (or on-site primary care physician, if a BHP is not available) must assess the detainee after the detainee is removed from suicide or constant watch, consistent with the procedures described in the Protocol for Suicide Watch (Appendix C).

(a) The BHP (or on-site primary care physician, if a BHP is unavailable) must assess the detainee for the presence of mental health symptoms, including persisting suicidal ideations within 72 hours after the detainee is discharged from suicide or constant watch.

(b) The BHP must determine whether additional follow-up appointments are required in accordance with the clinical presentation of the detainee.

(c) If additional follow-up appointments are required, the BHP must assess the detainee at each follow-up appointment for the presence of mental health symptoms, including suicidal ideation.

(3) The BHP, primary care physician, CD or clinical designee are the only providers with authority to remove a detainee from suicide or constant watch.

(4) If the detainee is determined to not be actively suicidal, the detainee should be transitioned off of suicide watch and to a less restrictive level of care (e.g., constant watch, mental health observation) or released to general population, if clinically appropriate. The clinical team (e.g., BHP, primary care physician, CD) should collaborate to determine whether discontinuation of suicide watch is appropriate.

(5) IHSC HQ Senior Leadership may instruct a facility, at any time, to have two providers evaluate a detainee in order to discontinue a suicide or constant watch. The specifics of the process will be determined by IHSC HQ senior Leadership

(a) If a two evaluator discharge is required, one evaluator must be a BHP and the other evaluator must be a BHP or primary care physician.

(b) The discharge disposition must be documented in the health record by both evaluators.

i. Children

(1) An actively suicidal child (17 years of age or younger) must be referred and transferred to a local hospital for evaluation and treatment as soon as possible.

(a) Until the transfer to a local hospital occurs, the child must be immediately placed on constant watch with one-to-one continuous observation and the BHP or primary care physician must assess the child using the "Initial Mental Health Suicide Risk Assessment" form.

(b) If a BHP or primary care physician is not available to conduct the evaluation, the child must remain on one-to-one continuous observation until transferred to local hospital.

(c) The child's parent should accompany the child through the hospital admission process while under the supervision of ICE. The hospital should determine if the parent is allowed to stay overnight. If allowed, the parent should stay overnight with the child; if not allowed, the parent should be granted visitation.

(2) A potentially suicidal child (17 years of age or younger) must be placed in the least restrictive setting or in the MHU with one-to-one continuous observation for up to 24 hours, until the BHP or primary care physician refers the child to a local hospital or releases the child from observation.

(a) The child's parent should be allowed in the MHU only if their presence is not a safety issue.

(b) Medical staff must document the status of the child in observation every two hours or more frequently as determined by the BHP.

(c) Custody staff must document observations every (b)(7)(E) (See ICE/DRO Residential Standard, Suicide Prevention and Intervention.)

j. Intervention/Responding to a Suicide Attempt in Progress

(1) Arriving health staff shall perform appropriate medical evaluation and intervention. The CD or designee is notified in situations for which referral to the emergency room of a local hospital is required.

k. Notification, Reporting, and Reviews of an Attempted/Completed Suicide

(1) In the event of an attempted suicide/completed suicide, the nurse-in-charge notifies the HSA, CD, and BHP immediately via phone and email. Serious suicide attempts and completed suicides are subject to the mortality review process.

(2) Every completed suicide, as well as a serious suicide attempt (i.e., requiring medical treatment and/or hospitalization outside the facility), should be examined through a multidisciplinary morbidity-mortality review process that includes representation from ICE, mental health, and medical. The primary purpose of the review is two-fold: "What happened in the case under review?" and "What can be learned to reduce the likelihood of future incidents?"

The review should include a critical inquiry of:

The circumstances surrounding the incident
Facility procedures relevant to the incident
All relevant training received by involved staff
Pertinent medical and mental health services/reports involving the incident
Possible precipitating factors (i.e., circumstances which may have contributed to the suicide or serious suicide attempt)
Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures

l. Psychological First Aid

(1) For completed suicides, the HSA or designee offers psychological first aid to detainees and staff involved in the incident within 72 hours of the event. For staff, additional services are available through respective human resource programs. Detainees may be referred to in-house BHPs or chaplains for further support.

m. Self-Harm and Suicide Identification and Response Training

(1) All health staff receives training during orientation and annually thereafter. All staff working with detainees remains current on the proper course of intervention and referral for a detainee showing signs of suicide risk.

(2) The HSA or designee approves the training curriculum for staff, including development of intake screening for potential and referral protocols, and training for staff conducting the suicide screening at intake.

6. Applicable Standards:

Performance-Based National Detention Standards (PBNDS) 2011:

4.6 Significant Self-Harm and Suicide Prevention and Intervention

ICE/DRO Residential Standard 2007:

4.5 Suicide Prevention and Intervention

National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails 2014:

J-G-05: Suicide Prevention Program

7. Applicable References:

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention, Appendix F (http://www.ncbi.nlm.nih.gov/books/NBK109908/).

Carlson, David K., Psy.D. *Jail Suicide Assessment Tool.* Jail Screening Assessment Tool (JSAT) User Manual: Guidelines for Mental Health Screening in Jails, 2002, 1-12.

White, Thomas W., PhD. How to Identify Suicidal People: A Systematic Approach to Risk Assessment, 1999, 116-121.

8. Appendices:

Appendix A - Initial Suicide Risk Assessment

Appendix B – Follow-Up Mental Health Suicide Risk Assessment

Appendix C - Protocol for Suicide Watch

9. HISTORICAL NOTES: This document replaces version 1, dated 2 Feb 2016

Appendix A- Initial Suicide Risk Assessment (To be formatted into eCW)

Reference: *** Insert/Expand Comment Box

Detainee/Resident Referred by:
Medical Staff Custodial Staff Self-Referral ***Other

Narrative (What led to the referral and other pertinent information):
***Expands to Comment Box

Risk Factors:
(+) present (-) absent n/a

***Current thoughts of suicide
***Current suicidal intent
***Current suicidal plan
Feelings of hopelessness/helplessness
***Feeling like a burden to others
***Fear for own safety
***Recent significant loss
***Social isolation (if yes, these selections will open up)
***detainee/resident withdrawn in general population
***housed in segregation
***lack of family connections
***Current physical pain
(Insert pain scale: 1-10) and explanation box
***Sleep problems
***Agitation (e.g., restlessness, irritability, anxious, increased psychomotor activity, etc.)
***Current Intoxication or in withdrawal from a substance
***Adjustment to ICE detention (adequate/inadequate)
***Problem solving deficits (e.g., rash decision making, inadequate strategies to get needs met, impulsivity, etc.)
***Uncontrolled mental health symptoms
***Non-compliance with mental health treatment
Chronic medical condition
***History of self-injury or suicidal behavior
Explain (e.g., when, method, patient's reaction, etc.)
***Family history of suicide
Explain (who, when, how did detainee/resident react, etc.)
***History of violent behavior
***History of mental illness
***History of inpatient psychiatric hospitalizations
Explain (e.g., when, duration of treatment, reason for hospitalization, etc.)
***History of childhood abuse (physical/sexual)

Protective Factors:
(+) present (-) absent n/a

***Able to identify reasons for living
Denial of suicidal ideations
***Fear of death
***Future orientation (e.g., plans for the future, etc.)
Adequate problem solving skills
Religious beliefs against suicide
***Social support in detention center
***Supportive family relationships
Willingness to engage in mental health treatment

Mental Status Exam:
Appearance
Attitude
Psychomotor Activity
Abnormal Body Movements
Attention
Degree of Awareness of Surroundings
Orientation
Affect
Mood
Speech
Judgement
Thought Content
Perceptual Disorders
Abstraction
Aggression
Anger Control
Current Suicidality
Current Homicidally
Intelligence (estimate)
Impulse Control
Sexual Impulse Control

Suicide Risk Assessment:

High Acute Risk: psychiatric hospitalization or 1:1 suicide watch indicated/continued (consideration for "high acute risk" include, but are not limited to, current suicidal ideations with organized plan and/or intent, recent self-injurious behavior with suicide intent)

Moderate Acute Risk: 1:1 suicide watch indicated/continued (consideration for "moderate acute risk" include, but are not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress)

Low Risk: Mental Health Observation with or without 15 irregular custody checks (consideration for "low acute risk" include, but are not limited to, suicidal ideation with no organized plan or intent with high acute distress, transitioning from 1:1 suicide watch)

Minimal Risk: Return to general population (consideration for "minimal acute risk" include, but are not limited to, absence of active suicidal ideation and moderate to low levels of acute distress)

Other

Constant Watch: 1:1 continuous observation indicated/continued (consideration for "constant watch" include, but are not limited to, exacerbation of mental health symptoms, risk of acute decompensation, concerns of potential self-injurious behavior)

Mental Health Follow Up:

Today	Within 72 hours
Tomorrow	Other

Appendix B – Follow-Up Suicide Risk Assessment (To be formatted into eCW)

Reference: *** Insert/Expands to Comment Box

Risk Factors:
(+) present (-) absent n/a

***Current thoughts of suicide
***Current suicidal intent
***Current suicidal plan
Feelings of hopelessness/helplessness
***Feeling like a burden to others
***Fear for own safety
***Current physical pain
(Insert pain scale: 1-10) and explanation box
***Sleep problems
***Agitation (e.g., restlessness, irritability, anxious, increased psychomotor activity, etc.)
***Uncontrolled mental health symptoms
***Non-compliance with mental health treatment

Mental Status Exam:
Appearance
Attitude
Psychomotor Activity
Abnormal Body Movements
Attention
Degree of Awareness of Surroundings
Orientation
Affect
Mood
Speech
Judgement
Thought Content
Perceptual Disorders
Abstraction
Aggression
Anger Control
Current Suicidality
Current Homicidally
Intelligence (estimate)
Impulse Control
Sexual Impulse Control

Suicide Risk Assessment:

High Acute Risk: psychiatric hospitalization or 1:1 suicide watch indicated/continued (consideration for "high acute risk" include, but are not limited to, current suicidal ideations with organized plan and/or intent, recent self-injurious behavior with suicide intent)

Moderate Acute Risk: 1:1 suicide watch indicated/continued (consideration for "moderate acute risk" include, but are not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress)

Low Risk: Mental Health Observation with or without 15 irregular custody checks (consideration for "low acute risk" include, but are not limited to, suicidal ideation with no organized plan or intent with high acute distress, transitioning from 1:1 suicide watch)

Minimal Risk: Return to general population (consideration for "minimal acute risk" include, but are not limited to, absence of active suicidal ideation and moderate to low levels of acute distress)

Other

Constant Watch: 1:1 continuous observation indicated/continued (consideration for "constant watch" include, but are not limited to, exacerbation of mental health symptoms, risk of acute decompensation, concerns of potential self-injurious behavior)

Mental Health Follow Up:

Today	Within 72 hours
Tomorrow	Other

Appendix C – Protocol for Suicide Watch

Initiation of Suicide Watch (One-to-One Continuous Visual Observation)

1) Notify the CD or designee, nurse manager, psychiatrist and treating team when a suicide watch is initiated on a detainee. Place a telephone encounter to the CD or designee (primary care physician, psychiatrist and/or BHP) requesting documentation of medical orders.

2) Document the following within the detainee's health record:

   Completed "Initial Suicide Risk Assessment" (Appendix A).
   Environment (e.g., single person room).
   Level of supervision (e.g., one-to-one continuous visual observation).
   Intervals of nursing checks.
   Clothing is limited to the suicide smock and blanket. Special consideration for flexible appropriate attire should be given to detainees with special vulnerabilities (e.g., actively menstruating females, detainees who suffer from incontinence and detainees who have a colostomy, etc.). The BHP and/or primary care physician must authorize these special considerations prior to implementation.
   Issued a Special Needs form for finger foods only and no utensils with meals.
   Property (e.g., personal belongings; clothing, toiletries).
   Initiate a Global Alert within the health record.
   Create a treatment plan.

3) Complete a Special Needs Form to indicate placement on suicide watch and place in the health record.

4) The BHP or primary care physician must reassess the detainee's status daily while on suicide watch utilizing the "Follow-Up Suicide Risk Assessment" (Appendix B). If the BHP or primary care physician is not on-site, an MLP can engage in the follow-up re-evaluation and will document their findings from their assessment in the progress note and send the note to the primary care physician for co-signature. The MLP will not utilize the "Follow-Up Suicide Risk Assessment" form to document their assessment.

5) If a detainee continues to have suicidal ideations with intent or the detainee's mental condition is not improving after 72 hours of being on suicide watch, the BHP, primary care physician, CD or clinical designee will review the medical record, take into account the detainee's full assessment and consider consultation with other BHP personnel, primary care physicians, and/or the CD regarding treatment plan and possible hospitalization.

Discharge from Suicide Watch

1) The BHP or primary care physician completes the "Follow-Up Suicide Risk Assessment" form (Appendix B) prior to a detainee's discharge from suicide watch. The discharge disposition must be documented in the health record.

2) The BHP or primary care physician places the detainee on mental health observation for at least 24 hours following discontinuation of suicide watch, if clinically indicated.

3) The BHP or primary care physician will determine if mental health observation must be continued.

4) When the detainee is deemed fit to be released from suicide watch or mental health observation to general population, the BHP or primary care physician completes a Special Needs Form.

5) The BHP or primary care physician documents the mental health follow-up treatment plan in the health record.